INDIANA STATE DEPARTMENT OF HEALTH
INDIANA HEALTH CARE PROFESSIONAL RECRUITMENT AND RETENTION FUND
Health Care Professional Student Loan Repayment Program

STUDENT LOAN REPAYMENT APPLICATION

Program Description:

The Indiana Health Care Professional Recruitment and Retention Fund Program (IHCPRRF) provides loan repayment for student loans incurred by health care professionals to encourage the full-time delivery of health care in shortage areas. The Indiana State Department of Health (ISDH) administers the fund. Primary Care Physicians (MD and DO) (family practitioners, internists, pediatricians, obstetricians and gynecologists); Primary Care Nurse Practitioners (NP); Certified Nurse Midwives (CNM); Primary Care Physician Assistants (PA); General Practice Dentists (DDS or DMD), and Dental Hygienists (DH) are eligible for the student loan repayment program. Physicians who have not completed a residency training program are not eligible for the student loan repayment program.

- The IHCPRRF Program allows the ISDH to repay *outstanding* student loans only, for expenses incurred during undergraduate or graduate education
- Health care professionals participating in the IHCPRRF Program must practice in *public or private not-for-profit settings* in federally designated shortage areas approved by the ISDH and, therefore, *cannot establish private practices.*
- **Loan repayment awards are considered personal income and are taxable.**

Loan Repayment Awards: Health care professionals may be granted up to the following amounts:

Service Year	IHCPRRF Award
1	$20,000
2	$20,000
Total	$40,000

Health Care Professional Requirements:

- Must be U.S. citizens.
- Must agree to provide services in an ISDH-approved, federally designated underserved area for *two years.*
- Must not have an outstanding contractual obligation for health professional service to the federal government or a state or other entity unless that service obligation will be completely satisfied before the contract has been signed.
- Must not be in breach of a health professional service contract to the federal government, a state or local government, or other entity.
- Must not have a judgment lien against their property for a debt to the U.S.
- Must perform the service obligations at an eligible site, i.e., public or nonprofit private entity located in a federally designated HPSA appropriate for their discipline and providing primary health care services.

- Must provide full-time primary health care services, which is defined as a minimum of 40 hours per week for at least 45 weeks per year for two years at an eligible site. At least 32 of the minimum 40 hours per week must be spent providing clinical service. These services must be conducted during normally scheduled clinic hours in the ambulatory care setting office(s), with the remaining hours spent providing inpatient care to patients of the eligible site and/or in practice-related administrative activities, with administrative activities not to exceed 20 percent of their full-time tour.

  Obstetricians/Gynecologists and certified nurse midwives are expected to spend not less than 21 hours per week providing ambulatory care services during normally scheduled office hours, with the remaining hours spent providing inpatient care to patients of the eligible site and/or in practice-related administrative activities, with administrative activities not to exceed 20 percent of their full-time tour.
- Must charge for their professional services at the usual and customary prevailing rates in the area in which such services are provided, except that if a person is unable to pay such charge, such person shall be charged at a reduced rate or not charged any fee.
- Must agree to provide primary health care services to any individual seeking care. The IHCPPRF Program participants must agree not to discriminate on the basis of the patient's ability to pay for such care or on the basis that payment for such care will be made pursuant to Medicare or Medicaid.
- Must agree to accept assignment under Medicare for all services for which payment may be made under Part B of Title XVIII and enter into an appropriate agreement with the state agency that administers the state plan for medical assistance under Title XIX to provide service to individuals entitled to medical assistance under the plan.
- Must pay the amount specified in their IHCPPRF Program contract default provision if they fail to complete their service obligation for any reason.

Interested Health Care Professionals meeting the requirements should: locate and secure a position at a suitable practice site (the ISDH maintains the list of HPSA locations); obtain an application from the ISDH; and submit the application and relevant documentation to the ISDH.

Practice Site Requirements:

Practice sites must be:

- Public or private not-for-profit entities located in a federally designated medical and/or dental HPSA.
- Committed to employing health care professionals full-time *for a minimum of two (2) consecutive years* (and up to 3 or 4 consecutive years if desired).
- If an applicant desires to practice in an area of need not designated as a HPSA, the applicant is required to document the need for primary health care professionals and the review committee will consider the suggested area of need as a potential practice location. (ISDH will seek HPSA designation and/or will waive the HPSA designation).

Interested persons should contact: Janet Chorpenning, Project Coordinator, Indiana Health Care Professional Recruitment and Retention Fund Program, Local Liaison Office, Indiana State Department of Health, 2 North Meridian Street, Indianapolis, Indiana 46204. Telephone: 317.233.1385.

PRIMARY CARE HEALTH PROFESSIONAL APPLICATION
INDIANA HEALTH CARE PROFESSIONAL RECRUITEMENT AND RETENTION FUND
STUDENT LOAN REPAYMENT APPLICATION
State Form 50775 (01-02)
INDIANA STATE DEPARTMENT OF HEALTH

CONFIDENTIAL INFORMATION (per IC 4-1-8)

SECTION I - PERSONAL DATA

Please type or print with ink.

Applicant Name: _____

Home Address: _____

City _____ State: _____ Zip Code: _____

Day Phone: ( ) _____ Evening Phone: ( ) _____

Social Security #: _____ Birth Date: _____

Is Applicant a United States citizen? ___ Yes No ___

Does Applicant have a current and unrestricted Indiana license to practice his/her profession? ___ Yes No ___

Is Applicant *free* of unserved obligations for service (e.g., federal, state, local government or other entity)? ___ Yes No ___ (If no, attach explanation)

Is Applicant *free* of judgments arising from federal debt? ___ Yes No ___ (If no, attach explanation)

SECTION II - HEALTH PROFESSION

___ M.D. ___ D.O.
___ Internist
___ Pediatrician
___ Obstetrician/Gynecologist
___ Dentist
___ Family Practitioner
___ Nurse Practitioner
___ Certified Nurse Midwife
___ Physician Assistant
___ Dental Hygienist

SECTION III - HEALTH PROFESSIONAL EDUCATION

School: _____ Date of Graduation: _____

City: _____ State: _____ Zip Code: _____

Postgraduate Training: _____

Board Eligible: _____ Board Certified: ____ IN License Number: _____

Certificate Number: _____ IN License Date: _____

SECTION IV - PRACTICE SITE

Note: The practice site must be in a shortage area for the profession designated by the ISDH.

Applicant agrees to provide full-time primary care services at:

Practice Site Name: _____

Address: _____

City: _____ County: _____ Zip Code: _____

Practice Site Contact Person: _____

Title: _____ Telephone No.: ( ) _____

Fax No. ( ) _____ E-mail Address: _____

Description of Practice Site:

_____ Community or Migrant Health Center _____ Hospital

_____ Maternal and Child Health Clinic _____ Health Facility

_____ Area Health Education Center _____ Nurse-managed Clinic

_____ Rural Health Clinic & Training Center _____ Other: _____

Type of Practice: _____ Public

_____ Private Not-for-profit

Private not-for-profit entities must attach a copy of their federal tax exempt letter, i.e., 501(c)(3)

Beginning Date of Practice: _____ (This is not the date IHCPRR service will begin.)

Number of Clinical Hours per Week at this Practice Location: _____

Include a copy of the contract between yourself and your practice site.

SECTION V - EDUCATIONAL DEBT

Estimate of total outstanding educational debt from all lenders: _____

Request submission of the attached *Lender Disclosure Form* from each loan holder.

Attach a current loan statement for each loan listed. Loan statements must contain Applicant's name, account number, and the principal and payoff balances.

(Attach additional copies of Section V if necessary)

SECTION V - EDUCATIONAL DEBT (continued)

1. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $ _____

2. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $ _____

3. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $ _____

4. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $ _____

5. Loan Holder _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $ _____

6. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $ _____

SECTION VI - CERTIFICATIONS (Notary Public Required)

I certify the following:

During the past 12 months, I have not discriminated, nor will I in the future discriminate against any persons seeking my medical/dental or other health care services. I charge fees at the customary rate prevailing in the area in which my services are provided, except that I charge fees at a reduced rate (using a sliding fee scale), or no fee at all for services provided to anyone who does not have the insurance or income to pay the usual fee. During the past 12 months, I have accepted and will continue to accept Medicare/Medicaid assignments as full payment for my services as established in Titles XIII and XIX of the Social Security Act.

All statements made in this Application are complete and accurate to the best of my knowledge. I understand that falsification will disqualify my application. I authorize representatives of the Indiana State Department of Health to contact institutions holding any of the listed educational loans, educational institutions that I attended, and employers to verify the accuracy of the information contained in this Application.

_____ _____

Applicant Signature (Full Legal Name) Date

Typed or Printed Name: _____

Social Security Number: _____

Sworn before me this _____ day of _____, 2001

_____

Notary Public (full legal signature)

Affix Seal My commission expires: _____

Mail your completed application to:

Indiana State Department of Health
Indiana Health Care Professional Recruitment and Retention Fund, 8-B
2 North Meridian Street
Indianapolis, Indiana 46204

Indiana Health Care Professional Recruitment and Retention Fund
Outstanding Educational Loan Debt Information

LENDER DISCLOSURE

Applicant: This form must be sent to each lending institution or agency for which you are seeking loan repayment. The lending institution should forward the completed form to our office.

Lender: If the named individual's application is approved, the requested information will be used to arrange third-party pre-payment of a portion or all of the applicant's debt.

Applicant's name as it appears on loan: _____

Original lending institution, federal or state program, please provide:

_____
Full Name of Institution or Program | Contact Person | Telephone Number

_____
Street Address | City | State | Zip Code

_____ $ _____ _____
Loan ID Number | Original Loan Amount | Date of Original Loan

_____ $ _____ _____
Grace Period/Forbearance Dates | Current Balance | Date of Balance

_____ % _____
Interest Rate | Simple or Compound

If interest rate is variable, explain terms: _____

Purpose of loan as indicated on the application: _____

Certification by Applicant Borrower:
I hereby authorize the government or financial institution named above to release information to the Indiana Health Care Professional Recruitment and Retention Fund for the purpose of repayment of outstanding health care professional education debt. I also certify the accuracy of the enclosed information and apply to enter into an agreement with the INDIANA HEALTH CARE PROFESSIONAL RECRUITMENT AND RETENTION FUND for repayment of all or the appropriate portion of the educational loan listed above, incurred solely to finance undergraduate, graduate, or health care professional education (not including residency).

Full Legal Signature: _____ Date: _____

Certification by Authorized Agent of Lending Institution:
The undersigned states that, to the best of his or her knowledge, the loan identified above is a bona fide, legally enforceable, commercial, state, or government educational loan, made for the purpose of meeting the borrower's costs of attaining health care professional education.

_____ _____
Print/Type Name of Authorized Agent | Title

Official Signature: _____